Washington State Health Care Authority

washington healthplanfinder
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Appeal/Hearing Request Form

Completing this form is not a requirement before requesting a hearing/appeal, but it may help us resolve issues more quickly. Complete and mail this form to:

Health Care Authority
PO Box 45504
Olympia, WA 98504-5504

You may also log in to your health benefits account at www.wahealthplanfinder.org to submit your hearing/appeal. If you have a question on the hearing or appeal process, call Washington Healthplanfinder at 1-855-923-4633.

Name: _____ Application ID: _____

Address: _____

Phone number: _____ Email: _____

Do you need help speaking, reading or writing English?

☐ No ☐ Yes: What language? _____

Check the boxes that best describes the reasons you are appealing.

- ☐ Health Insurance Premium Tax Credit was incorrectly denied or terminated.
- ☐ The amount of my premium for Health Insurance Premium Tax Credit is not correct.
- ☐ Washington Apple Health has been denied or terminated.
- ☐ The immigration/citizenship status of a household member is not correct.
- ☐ The members included in my household are not correct.
- ☐ The amount and/or type of income that was used to determine my eligibility is not correct.
- ☐ The overpayment that was established is not correct.
- ☐ Other reasons or additional comments. Please explain:_____

  _____

  _____

☐ Check this box if someone is going to help you with the hearing/appeal or represent you during the hearing/appeals process. This can be an attorney, friend or family member. Provide this person's contact information:

Name: _____ Phone: _____

Address: _____

Email: _____

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